STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000557	A. BUILDING: _____ B. WING _____	06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEYAN HEALTH CARE CENTER	729 W 35TH ST MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: June 10, 11, 12, 13, 16 and 17, 2014 Facility number: 000557 Provider number: 155455 AIM number: 100291240 Survey team: Jason Mench, RN, TC Angela Selleck, RN (June 10, 12, 13, 16 and 17, 2014) Kim Davis, RN (June 10, 11, 12, 13 and 17, 2014) Shelly Reed, RN Census bed type: SNF: 12 SNF/NF: 112 Residential: 8 Total: 132 Census payor type: Medicare: 12 Medicaid: 91 Other: 29 Total: 132 Residential sample: 7 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review completed by Debora Barth, RN.	R 000		
R 247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency	R 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000557	A. BUILDING: _____ B. WING _____	06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEYAN HEALTH CARE CENTER	729 W 35TH ST MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 247	Continued From page 1 (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. This RULE is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received the correct dose of medication according to the current physician order for 1 of 5 residents reviewed during medication administration. (Resident H). The facility also failed to ensure a medication error rate of less than 5 percent for 1 of 18 medications observed affecting 1 of 5 residents resulting in a medication error rate of 5.5%. (Resident H; LPN # 2) Findings include: 1. During medication administration observation on 6/17/14 at 3:00 p.m., LPN #2 administered Hydrocodone-Acetaminophen (pain medication) 5/325 mg to Resident (H). During review of the Medication Administration Record (MAR), provided by the Director of Nursing (DoN) on 6/16/14 at 3:30 p.m., the current physician's order indicated Resident (H) should have received Hydrocodone-Acetaminophen 5/500mg twice daily. During an interview on 6/16/14 at 3:38 p.m., the DoN indicated the nurse gave the wrong medication and the physician was notified. She indicated the facility wrote a medication error report for Resident (H). 2. There were 18 opportunities for medication	R 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000557	A. BUILDING: _____ B. WING _____	06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEYAN HEALTH CARE CENTER	729 W 35TH ST MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 247	Continued From page 2 errors during the medication pass observations. One error resulted. This made the error rate equal to 5.5%.	R 247		
R 408	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents received a tuberculin skin test on admission for 1 of 7 sampled residents. (Resident G) Findings include: 1. During clinical record review on 6/17/14 at 9:30 a.m., Resident (G) was admitted to the facility on 3/13/14. During review of the current immunization record, Resident (G) did not receive a 1st step tuberculin skin test or risk assessment until 3/19/14. The second skin tuberculin test was given on 4/7/14. During an interview on 6/17/14 at 1:30 p.m., the Corporate Nurse indicated Resident (G) did not receive a tuberculin skin test on admission. She was unsure why the resident did not receive the test on admission. No additional information was provided related to tuberculin skin tests.	R 408		